PARAGON HEALTHCARE

A Carelon Company

NEUROLOGY ORDER SET

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

Lab orders: _____ **Frequency**: ☐ Each infusion ☐ Other: _____

Required labs to be drawn by: ☐ Paragon ☐ Referring provider

THERAPY ORDER

Diagnosis	Infusion Orders
☐ Pompe Disease ICD-10: _____	☐ **Lumizyme** 20mg/kg IV every 2 weeks x1 year ☐ **Nexviazyme** 20mg/kg IV every 2 weeks x1 year
☐ Migraines ICD-10: _____	**Vyepti**: ☐ 100mg IV every 3 months x1 year OR ☐ 300mg IV every 3 months x1 year
☐ MS ☐ Other: _____ ICD-10: _____	☐ **Solu-Medrol** 1gm IV daily x _____day(s) OR ☐ Solu-Cortef 1gm IV daily x _____ day(s)
☐ Diagnosis: _____ ICD-10: _____	**Soliris**: *(neuro dosing)* ☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year (inital start with maintenance) ☐ 1200mg IV every 2 weeks x1 year (maintenance dosing)
☐ Multiple Sclerosis ICD-10: _____	☐ **Tysabri** 300mg IV every 4 weeks x1 year (after registering patient with TOUCH) ☐ **Ocrevus*** ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ☐ 600mg IV every 6 months x1 year ☐ **Ocrevus Zunovo** 920mg/23,000units subcutaneously every 6 months x1 year Premed protocol: dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes prior to Ocrevus Zunovo ☐ **Briumvi*** ☐ 150mg IV x1, then 450mg IV 2 weeks later, followed by 450mg IV every 24 weeks x1 year ☐ 450mg IV every 24 weeks x1 year ***Premed Protocol**: Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion
☐ Diagnosis: _____ ICD-10: _____	**IVIg** Orders: _____ mg/kg **OR** _____ gm/kg IV divided over _____ day(s) **Frequency:** Every _____ weeks x1 year **OR** _____ one time dose only Preferred brand: _____ (Paragon to choose if not indicated)
☐ Diagnosis: Myasthenia Gravis ICD-10: _____ ☐ Diagnosis: CIDP (Vyvgart Hytrulo) ICD-10: _____	**Ultomiris**: (neuro dosing) Loading dose: ☐ 2,400mg (40-59kg) ☐ 2,700mg (60-99kg) ☐ 3,000mg (100kg+) IV followed 2 weeks later by Maintenance dose of: ☐ 3,000mg (40-59kg) ☐ 3,300mg (60-99kg) ☐ 3,600mg IV (100kg+) IV every 8 weeks x1 year **Vyvgart***: ☐ 10mg/kg IV once weekly for 4 weeks (<120kg) ☐ 1200mg IV over 1 hour once weekly for 4 weeks (≥120kg) *Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Vyvgart Hytrulo**: ☐ 1,008 mg / 11,200 units subcutaneously Frequency: ☐ weekly for 4 weeks* OR ☐ every week x 1 year *Cycle may be repeated >50 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Rystiggo****: ☐ <50kg: 420mg ☐ 50kg to <100kg: 560mg ☐ ≥100kg: 840mg subQ weekly x6 **Cycle may be repeated ≥63 days from start of previous cycle. Subsequent cycles may be ordered as appropriate **Imaavy**: ☐ Initial start: 30mg/kg IV x1, then 15mg/kg IV 2 weeks later, then 15mg/kg IV every 2 weeks thereafter x 1 year ☐ Maintenance dose: 15mg/kg IV every 2 weeks x 1 year
☐ hATTR amyloidosis ICD-10: _____	☐ **Amvuttra** 25mg SubQ every 3 months x1 year
Pre-medication Orders	☐ Tylenol 1000mg PO ☐ Cetirizine 10mg PO ☐ Benadryl 25mg PO ☐ Benadryl 25mg IV ☐ Loratadine 10mg PO ☐ Cetirizine 10mg IV ☐ Solu-Medrol ____ mg IVP ☐ Other: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis

  Has the patient tried and failed previous drug therapy?

  If yes, which drug(s)? _____
- ☐ Labs attached
  - ☐ JCV antibody (Tysabri orders)
  - ☐ AChR antibody or MuSK antibody (Rystiggo, Imaavy, Vyvgart & Ultomiris)
  - ☐ Hepatitis B antigen and Hepatitis B core total antibody (Ocrevus & Briumvi)
  - ☐ Serum immunoglobulins (Ocrevus & Briumvi)
  - ☐ Other supporting labs based on diagnosis/order
- ☐ Diagnostic testing
  - ☐ MRI documentation (Tysabri, Ocrevus, Briumvi)
  - ☐ Other diagnostic testing to support diagnosis/order
- ☐ Vaccine record
  - ☐ Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris orders)
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance